State of California Department of Corrections and Rehabilitation

Memorandum

Date : FEB 17 2009

To : Tim Mahoney
Superintendent
Preston Youth Correctional Facility

Subject: **PEER REVIEW OF PRESTON YOUTH CORRECTIONAL FACILITY**

The Office of Audits and Compliance (OAC), in conjunction with the Division of Juvenile Justice conducted a Combined Operational Peer Review at Preston Youth Correctional Facility (PYCF) the week of November 17 through 21, 2008. The review included; Business Services, Ward Education Programs, Information Security, Security Operations, Health Care Services, and Safety and Security Standards, Section 1800.

This effort is designed to:

1. Provide PYCF with a comprehensive review;
2. Reduce overlap between audits; and
3. Improve operations and accountability

Attached are the Preliminary Review Reports of Findings and Recommendations which includes an Executive Summary. Please submit to OAC your corrective action plan (CAP) including time frames, target dates, and/or rebuttals within 45 days from the date of the preliminary report. Please ensure a CAP is completed for each of the respective areas reviewed.

If you should have any questions, please contact me at (916) 255-2990.

RICHARD C. KRUPP, Ph.D.
Assistant Secretary
Office of Audits and Compliance

Attachment

cc: Bernard Warner, DJJ
Sandra Youngen, DJJ
Brigid Hanson, DJJ
Doug McKeever, DJJ
Jim Cripe, DJJ

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OFFICE OF AUDITS AND COMPLIANCE

PRESTON YOUTH CORRECTIONAL FACILITY

EXECUTIVE SUMMARY

The Office of Audits and Compliance (OAC) worked with the Division of Juvenile Justice to conduct a peer review of Business Services, Security Operations, Health Care Services, Ward Education Programs, Information Security, and Safety and Security Standards, Section 1800 at Preston Youth Correctional Facility (PYCF) from November 17 through 21, 2008. The purpose of the review was to determine PYCF's compliance with departmental rules, regulations, policies and procedures.

Preliminary compliance reports were prepared for each of the reviewed areas. This executive summary identifies the significant issues identified in each of the preliminary reports. For more information on the areas of interest, please see the detailed preliminary report. OAC requests that PYCF provide a CAP 45-days after receipt of the preliminary report.

A summary of the significant issues is as follows:

Security Operations

Use of Force:

Staff inquiries not completed within time frames.

PYCF is not requesting a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

Business Services

Safety and Security:

Control over tools is inadequate.

Policies, Plans and Procedures:

PYCF does not have a Hazardous Waste Management Plan (Business Plan).

Health and Safety:

Plant Operations is not maintaining chemicals in accordance to the California Code of Regulations, Title 8.

The Audits Branch (AB) noted the following deficiencies regarding the cross-connection program:

- The master list that identifies the location, serial numbers, manufacturer, and the number of back flow devices, that are to be tested annually, could not be reconciled, as field tests do not exist.

- The AB could not determine how many backflow devices are located throughout the facility.
- There is no published cross-connection schedule for 2008.
- The AB could not determine whether all backflow devices are tested on an annual basis.

Communicating work place hazards are not performed in accordance with the PYCF-Illness and Injury Prevention Plan.

Late Detection and Additional Workload:

Documentation of testing and maintenance of the emergency generators is inadequate.

The AB noted that the methods of a Preventative Maintenance (PM) program are not being followed.

- Equipment/assets are not clearly identified with the standard equipment code on each piece of equipment (Maintenance Identifiers).
- Department/Facility goals are not delineated in the duty statements. For example, four of the eight duty statements reviewed do not direct staff to the percentage of time to be spent performing PM.
- Scheduled maintenance for the emergency generators, backflow devices, and emergency lighting is not being followed.

The Chief of Plant Operations or selected key staff are not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities, such as a space utilization committee. In addition, space action requests were not used.

Health Care Services

Health Care Services Request Forms:

Lack of documentation.

Psychologist's documentation not in the UHR.

Ward Education Programs

Student Enrollment:

Special Education/English Language Learner students not assigned to school within four days of arrival.

General Education student not assigned to school within four days of arrival.

Information Security

Ward Computer Labels: Ward computers were not labeled “For Ward authorized access.”

Ward Computing Environment: All ward access to computer operating systems must be restricted.

Ward Antivirus Software: Ward accessed computers do not have up-to-date antivirus software.

Safety and Security

Section 1800:

The Multi-Hazard plan did not contain contact information for the Office of Emergency Services.

The Multi-Hazard plan did not contain a signed local mutual aid agreement with local law enforcement.

State of California Department of Corrections and Rehabilitation

Memorandum

Date : February 17, 2009

To : Tim Mahoney
Superintendent
Preston Youth Correctional Facility

Subject: **PRELIMINARY AUDIT REPORT OF THE PLANT OPERATIONS - PRESTON YOUTH CORRECTIONAL FACILITY**

Attached is the Preliminary Audit Report of Findings and Recommendations developed during the audit of Plant Operations at Preston Youth Correctional Facility. The Office of Audits and Compliance (OAC), Audits Branch conducted the fieldwork during the period of November 17, 2008 through November 24, 2008. A complete description of each finding, its impact, criteria and recommendation is contained within the narrative portion of the report.

There are nine findings identified in the preliminary report categorized under the sections of Safety and Security, Policies, Plans and Procedures, Health and Safety, Late Detection, and Additional Workload.

Please provide, within 45 days, a brief description of your Corrective Action Plan (CAP) for each finding and a date when you expect the finding to be resolved. The OAC will issue a final report within 60 days after receipt of your CAP.

A follow-up audit will be scheduled as deemed necessary. Should you have any specific questions, please contact René Francis at (916) 255-2944 or Michael Robinson at (916) 255-2666. For general information call Patricia Weatherspoon at (916) 255-2729.

Original signed by

RICHARD C. KRUPP, Ph.D.
Assistant Secretary
Office of Audits and Compliance

Attachment

cc: René Francis, OAC
Patricia Weatherspoon, OAC
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CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
OFFICE OF AUDITS AND COMPLIANCE

REPORT OF FINDINGS AND RECOMMENDATIONS

PLANT OPERATIONS

PRESTON YOUTH CORRECTIONAL FACILITY

NOVEMBER 17–24, 2008

PRELIMINARY REPORT

CONDUCTED BY

THE AUDITS BRANCH

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OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

PRESTON YOUTH CORRECTIONAL FACILITY

INTRODUCTION

The California Department of Corrections and Rehabilitation's, Office of Audits and Compliance (OAC), Audits Branch conducted an audit of Plant Operations at Preston Youth Correctional Facility (PYCF). The purpose of the audit was to analyze and evaluate the level of compliance with State and departmental policies, procedures, rules, regulations, operational objectives, and guidelines. The policies, procedures, and guidelines consisted of the Youth Administrative Manual (YAM), the Institution and Camps Branch Manual (I&C Manual), the California Code of Regulations (CCR), the Penal Code, General Industrial Safety Orders (GISO), the PYCF Policy and Procedures Manual and the California Department of Health Services (DHS) Environmental Health Surveys.

The following areas within Plant Operations were audited:

- Organizational Charts, Mission, and Duty Statements;
- Communication/Performance Evaluations;
- Policies and Procedures;
- Inspection of Facilities, Systems, and Equipment;
- Training Plans;
- Life, Health, and Safety Management;
- Warehousing and Inventory Control;
- Hazardous Material Handling;
- Tool Control;
- Work Orders;
- Preventive Maintenance;
- Space Management;
- Construction Activity;
- Utilities; and
- Fiscal Management.

The fieldwork was performed during the period of November 17-24, 2008. The exit conference was held on November 24, 2008.

René Francis, Certified Government Financial Manager, supervised the audit. Management Auditors, Annette Sierra and Michael Robinson conducted the audit. Patricia Weatherspoon, Senior Management Auditor provided second line supervision, management, and review. Richard C. Krupp, Assistant Secretary of OAC, provided executive management oversight.

The audit consisted of an entrance conference, review of the prior audits, test of transactions, interviews, observations, briefings, an exit conference, and issuance of the preliminary audit report.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

Preston Youth Correctional Facility

AUDIT SCOPE

The scope of the audit encompasses the examination and evaluation of the adequacy and effectiveness of PYCF's system of management control and compliance to applicable policies, procedures, rules, and regulations. The audit period may include prior fiscal years, if deemed necessary. The control objectives include, but are not limited to the following:

- State assets are safeguarded from unauthorized use or disposition;
- Transactions are executed in accordance to management's authorizations;
- Transactions are executed in accordance with applicable rules and regulations;
- Transactions are recorded correctly to permit the preparation of financial and management reports; and
- Programs are working efficiently and effectively.

In order to determine the adequacy of the control systems and level of compliance with State, federal, and departmental fiscal procedures, the audit team performed the following audit procedures:

- Examined evidence on a test basis supporting management's assertions;
- Performed detailed analyses of documentation and transactions;
- Interviewed facility staff;
- Made inspections and observations;
- Performed group discussions of the overall impact of deficiencies; and
- Discussed deficiencies with supervisors and management throughout the audit process.

SYMPTOMS OF CONTROL DEFICIENCIES

Experience has indicated that the existence of one or more of the following danger signals will usually be indicative of a poorly maintained or vulnerable control system. These symptoms may apply to the organization as a whole or to individual units or activities. Department heads and managers should identify and make the necessary corrections when warned by any of the danger signals listed below:

- Policy and procedural or operational manuals are either not currently maintained or are nonexistent;
- Lines of organizational authority and responsibility are not clearly articulated or are nonexistent;
- Financial and operational reporting is not timely and is not used as an effective management tool;
- Line supervisors ignore or do not adequately monitor control compliance;
- No procedures are established to assure that controls in all areas of operation are evaluated on a reasonable and timely basis;
- Internal control weaknesses detected are not acted upon in a timely fashion; and
- Controls and/or control evaluations bear little relationship to organizational exposure to risk of loss or resources.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

Preston Youth Correctional Facility

EXECUTIVE SUMMARY

The Audits Branch conducted an audit of the Plant Operations at PYCF from November 17-24, 2008. The purpose of the audit was to determine the level of compliance with State, federal, and departmental rules, regulations, policies, and procedures.

The policies, procedures, and guidelines consisted of the YAM, the I&C Manual, the CCR, the Penal Code, GISO's, the PYCF Policy and Procedures Manual, and the DHS Environmental Health Surveys.

The exit conference was held on November 24, 2008. The Audits Branch requested that PYCF provide a corrective action plan within 45 days of receipt of the preliminary audit report.

Areas audited:

- Organizational Charts, Mission, and Duty Statements;
- Communication/Performance Evaluations;
- Policies and Procedures;
- Inspection of Facilities, Systems, and Equipment;
- Training Plans;
- Life, Health, and Safety Management;
- Warehousing and Inventory Control;
- Hazardous Material Handling;
- Tool Control;
- Work Orders;
- Preventive Maintenance;
- Space Management;
- Construction Activity;
- Utilities; and
- Fiscal Management.

Nine findings are identified in the preliminary audit report, categorized under the following topics:

Category	Number of Findings	Page Number
Safety and Security	1	1
Policies, Plans, and Procedures	1	2
Health and Safety	4	3
Late Detection and Additional Workload	3	6
Total	**9**	

I. SAFETY AND SECURITY

1. Tool Control

The Boiler House, Motor Pool, and Grounds Shop were reviewed to determine the level of compliance with the tool control policies stated in the PYCF Policy and Procedures Manual and the I&C Manual. One deficiency is identified in the Boiler House; multiple deficiencies were identified in the Motor Pool as well as the Grounds Shop. This is common to all three areas. Additionally, the master inventory does not reconcile with the shadow boards or the tool box.

Impact: This issue could result in late detection of missing tools.

II. POLICIES, PLANS, AND PROCEDURES

PYCF does not have a Hazardous Waste Management Plan (Business Plan). The complete Plan must be approved and signed by the Superintendent (Business Owner) before submission to the Amador County Certified Uniform Program Agency (CUPA) or the Administering Agency (AA). CCR, Title, 19.

Impact: This issue makes it difficult to determine accountability over the Business Plan and may result in an increased threat to life, health, and safety. In addition, the lack of compliance may result in revocation of a permit.

III. HEALTH AND SAFETY

The Audits Branch noted deficiencies regarding the Hazardous Communication Program (HCP) at the Boiler House, Motor Pool, Grounds Shop, and the Main Accumulation Site. A common deficiency found at all four locations is that a daily perpetual inventory of chemicals is not conducted and labels may contain incorrect information. Additionally, Material Safety Data Sheets (MSDS) are not maintained for chemicals stored and used. PYCF's Policy and Procedures Manual, Section 9800; and CCR, Title 8.

Impact: This results in an increased threat to life, health, and safety.

The chemicals used for pest/vector control are not safely stored. For example, there is no ventilation where chemicals are stored, no inventory of chemicals is conducted, and flammable and caustic chemicals are stored in wooden cabinets. Additionally, staff and wards are not adequately notified before applications of pesticides are administered.

PYCF's Policy and Procedures Manual, Section 9140; Bargaining Unit (BU) 1 Agreement.

Impact: This issue results in an increased threat to life, health, and safety, and gives the appearance that the PYCF has not maintained an effective Illness and Injury Prevention Plan (IIPP).

The Audits Branch noted the following deficiencies regarding the cross-connection program:

- The master list that identifies the location, serial numbers, manufacturer, and the number of back flow devices, that are to be tested annually, could not be reconciled, as field tests do not exist.
- The Audits Branch could not determine how many backflow devices are located throughout the facility.
- There is no published cross-connection schedule for 2008.
- The Audits Branch could not determine whether all backflow devices are tested on an annual basis.

Impact: It is difficult to determine whether backflow tests have been performed.

Communicating work place hazards are not performed in accordance with the PYCF's IIPP. The Audits Branch noted the following deficiencies:

- Machinery (i.e., lathes, drill presses, etc) do not have an emergency shut off.
- Safety signage is not posted (i.e., do not operate near flammable liquid; Personal Protection Equipment (PPE) must be worn, etc). PYCF's IIPP; and CCR, Title 8.

Impact: This issue results in duties not being performed in a safe and healthy manner.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

Documentation of testing and maintenance of the emergency generators is inadequate. PYCF's Policy and Procedures Manual, Section 9630.

Impact: In case of an emergency, such as the loss of electricity; the alternate electrical supply may fail. In addition, there is no documentation to determine whether the emergency generators are tested according to policy. Preventive Maintenance (PM) of equipment is not performed and documented. PYCF's Policy and Procedures Manual, Section (new).

Impact: This issue could result in late detection of equipment problems, decrease efficiency, and increase downtime. Additionally, this condition may result in repair costs.

The Chief of Plant Operations (CPO) or selected key staff is not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities, such as a space utilization committee. Additionally, space action requests are not used. YAM, Section 9400.

Impact: This issue could result in difficulty accomplishing the goals and objectives of the institutions space management.

FINDINGS AND RECOMMENDATIONS

I. SAFETY AND SECURITY

1. Tool Control

Control over tools is inadequate. The Audits Branch noted deficiencies in the following areas:

Boiler House:

- The master inventory list does not reconcile to the shadow board.

Motor Pool (auto shop)

- The master inventory list does not reconcile to the shadow board. The Audits Branch noted crowbars, sledgehammers, and extension cords are not tagged, scribed, and placed on the inventory.

Grounds Shop

- All tools are not stored in the designated tool room.
- The master inventory list does not reconcile to the shadow board.
- There are excessive tools that have been donated that are not tagged, scribed, and placed on the inventory.

This issue could result in late detection of missing tools.

PYCF's Policy and Procedures Manual, Section 3192, Tools, General Policy, states: "Shop Supervisors are responsible for establishing and maintaining specific plans to ensure the tool control procedure is carried out in all areas under their supervisors. All tool storage areas will include, in plain view, an accurate, up-to-date tool control inventory."

I&C Manual, Section 1821, states: "Each facility shall have a detailed written policy on tool control for all areas of the institution."

Recommendation

Review the current policies and procedures related to tool control. Determine which ones apply to PYCF and develop a plan/strategy to ensure that tool control is administered in accordance with applicable policies and procedures.

II. POLICIES, PLANS AND PROCEDURES

1. Hazardous Waste Management Plan (HWMP)

PYCF does not have a HWMP (Business Plan). The plan should consist of the following:

- The complete Plan must be approved and signed by the Superintendent (Business Owner) before submission to the Amador County CUPA or AA.
- The Business Plan must include the name and phone number of the emergency contacts (primary and secondary).
- The Plan must include the Spill Prevention, Control and Counter Measure Plan (SPCC) for the above ground storage tanks.
- The SPCC must contain written monitoring procedures.

This issue makes it difficult to determine accountability over the Business Plan and may result in an increased threat to life, health, and safety. In addition, the lack of compliance may result in the revocation of a permit.

CCR, Title 19, Section 2729.2, states: "A business subject to the requirements of Section 2729.1 shall complete and submit to the CUPA or AA the following to satisfy the inventory are :

The Business Activities Page,

The hazardous materials with chemical description,

An annotated site map, forms described and their completion instructions. A site map (public document) and storage map (confidential document) must be included in the Business Plan."

Amador County Permit Conditions, states: "Major changes in the business plan, including the change of name or phone number of the 24 hour emergency contacts, must be reported to the CUPA or AA within 30 days. The permittee must comply with, and maintain onsite, copies of a current permit and the attached: written monitoring procedures, emergency response plans, and a plot plan designating the location where monitoring will be performed.

Recommendation

Establish and maintain a current/complete and approved HWMP-Business Plan.

III. HEALTH AND SAFETY

1. Hazardous Communication Program

Plant Operations are not maintaining chemicals in accordance to the CCR, Title 8. The Audits Branch also noted additional deficiencies at the following locations regarding the HCP:

Boiler House:

- A chemical inventory is not conducted.
- Flammable chemicals, such as re-agents (sulfuric acid) are maintained in a wooden cabinet.
- Incompatible substances are maintained on the same shelf.
- Kitchen appliances (toaster oven, microwave, coffee pot) are maintained and used next to chemicals, states: “Do not use near heat or flames.”
- The index of the MSDS binder is not user friendly.

Motor Pool (auto shop):

- Hazardous waste labels are not used.
- MSDS are not maintained for chemicals stored and used.
- A chemical inventory is not conducted.

Grounds Shop:

- A daily perpetual chemical inventory is not conducted.
- MSDS are not maintained for chemicals stored and used.
- Hazardous waste is maintained on a wooden pallet versus secondary containment.
- Secondary containers are used without labels.
- A chemical inventory is not conducted.

Main Accumulation:

- Empty drums are not marked “Empty.”
- Secondary containment is not used for 55-gallon drums, porous wooden pallets are.
- There is no signage indicating the potential hazard of hazardous waste being stored.

This issue results in an increased threat to life, health, and safety.

PYCF's Policy and Procedures Manual, Section 9800, Hazardous Communication Standard Procedure, states: "All toxic substance containers shall bear labels identifying the name of the toxic substance and the appropriate hazard warnings. All toxic substances shall be used, stored, and disposed of according to label directions and applicable laws and regulations."

CCR, Title 8, Section 5194, HCP, states in part: "Department heads shall monitor daily compliance with this procedure in the areas of their responsibility . . . . Each area supervisor shall ensure that every person required to work with or use hazardous, toxic, volatile substances is appropriately trained."

CCR, Title 15, Section 3303 (b), states: "Institution heads shall maintain procedures for controlling the following safety and security hazards within the facility: Control of harmful physical agents and toxic or hazardous substances."

Recommendation

Comply with the PYCF's, Policy and Procedures Manual relating to the handling, controlling, safeguarding, and dispensing of dangerous and toxic substances.

2. Pest/Vector Control

The chemicals used for pest/vector control are not safely stored. For example, there is no ventilation in the building where chemicals are stored, a chemical inventory is not conducted, and flammable and caustic chemicals are stored in wooden cabinets. Additionally, staff and wards are not adequately notified before applications of pesticides are administered.

This issue results in an increased threat to life, health, and safety, and gives the appearance that PYCF has not maintained an effective IIPP.

PYCF's Policy and Procedures Manual, Section 9140, Vector Control, states: "To see that chemicals are stored safely."

PYCF's Policy and Procedures Manual, Section, 9800, Hazardous Communication Standard, states in part: ". . . supervisor is responsible for maintaining a running inventory of all flammable, toxic, and caustic substances used and stored in their areas . . ."

BU 1 Agreement, states: "Whenever a department utilizes a pest control chemical in a state owned or managed building/grounds, the department will provide at least forty-eight hours notice prior to application of the chemical, unless an infestation occurs which requires immediate action. Notices will be posted in the lobby building and will be disseminated to building tenant contacts."

Recommendation

Comply with the PYCF's Policy and Procedures Manual, section for the handling, controlling, safeguarding, and dispensing of dangerous and toxic substances.

3. Cross-Connection Program (Back-flow devices)

The Audits Branch noted the following deficiencies regarding the cross-connection program:

- The master list that identifies the location, serial numbers, manufacturer, and the number of back flow devices, that are to be tested annually, could not be reconciled, as field tests do not exist.
- The Audits Branch could not determine how many backflow devices are located throughout the facility.
- There is no published cross-connection schedule for 2008.
- The Audits Branch could not determine whether all backflow devices are tested on an annual basis.

This issue results in difficulty determining whether backflow tests have been performed.

The California Plumbing Code, Section 603.3.2, states: "The premise owner or responsible party shall have the backflow prevention assembly tested by a certified backflow assembly tester at the time of installation, repair, or relocation and at least on an annual schedule thereafter or more often when required." The DHS Drinking Water and Environmental Management Division recommends that test results should be kept on file in a central location.

Recommendation

Create a master list or use a plot plan to identify all locations and devices, maintain accurate data, and test backflows on an annual basis. Continuous education of staff should be encouraged.

4. IIPP

Communicating work place hazards are not performed in accordance with the PYCF's IIPP. The Audits Branch noted the following deficiencies:

- Machinery (i.e., lathes, drill presses, etc.) do not have an emergency shut off.
- Safety signage is not posted (i.e., do not operate near flammable liquid, PPE must be worn, etc.).

This issue could result in duties not being performed in a safe and healthy manner.

PYCF's IIPP, page 5, Section VI, states inpart: "Effective communications with employees have been established which include the following methods to meet the standard requirements: Other forms of employer-to-employee communications on safety topics include (specific posters, letter, meeting, etc.) . . . ."

CCR, Title 8, Section 3203 (D), states in part: "Maintenance of all written documents for five years. Other forms of employer-to-employee communications on safety topics include specific posters letters meetings etc. ...Local procedures include but are limited to Code of Safe Practices and other job-specific hazards . . ." Reference: CCR, Title 8, Sections 1669-1672.

Recommendation

Maintain an effective IIPP with employer-to-employee communications.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

1. Emergency Generators

Documentation of testing and maintenance of the emergency generators is inadequate.

- The log used to document maintenance does not show: 1) which maintenance or testing procedure is performed, 2) the generator number, and 3) who performed the test.
- Scheduled PM on the generators is not always performed.

In case of an emergency, such as the loss of electricity, the alternate electrical supply may fail. In addition, there is no documentation to determine whether the emergency generators are tested according to policy.

The PYCF's Policy and Procedures Manual, Section 9630, Generator Testing, states: "1. Ensure that emergency generators are tested 480v weekly, 4160v every two weeks and under full load once per month, the results of testing is recorded and maintained for review."

Recommendation

Establish and maintain a log for the testing of the emergency generators that details which tests are performed, the results, the date test is performed, and who performed the test. Also, ensure that this log is kept for review. In addition, ensure that PM is performed and monitored for compliance.

2. Maintenance

The Audits Branch noted that the methods of a PM program are not being followed.

- Equipment/assets are not clearly identified with the standard equipment code on each piece of equipment (Maintenance Identifiers).
- Department/facility goals are not delineated in the duty statements. For example, four of the eight duty statements reviewed do not direct staff to the percentage of time to be spent performing PM.
- Scheduled maintenance for the emergency generators, backflow devices, and emergency lighting is not being followed.

This issue could result in late detection of equipment problems, decrease efficiency, and increase downtime. Additionally, this condition may result in repair cost.

The PYCF's Policy and Procedures Manual, Section (New), PM Procedure, states in part: "Establish an effective and efficient PM procedure. This procedure must establish the systematic maintenance of all major institutional facilities and equipment…Without such program equipment will wear out prematurely, structures will deteriorate, and efficient function of the facility will be compromised."

Recommendation

Establish a PM schedule for all major equipment. Determine the tasks that are to be performed and train staff as necessary to ensure proper performance of PM is properly performed.

3. Space Utilization

The CPO or selected key staff are not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities, such as a space utilization committee. In addition, space action requests were not used.

This issue could result in difficulty accomplishing the goals and objectives of the institution space management.

The YAM, Section 9400, states: "Staff shall follow procedures established herein to obtain space for new offices or programs; to renew leases for existing facilities; to propose alterations to existing facilities; or to obtain living facilities for the departments' wards."

Recommendation

Review the YAM policy and select employees to participate in a facility wide committee, such as the Space Utilization Committee.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

PRESTON YOUTH CORRECTIONAL FACILITY

GLOSSARY

AA	Administering Agency
BU	Bargaining Unit
CCR	California Code of Regulations
CPO	Chief of Plant Operations
CUPA	Certified Uniform Program Agency
DHS	Department of Health Service
GISO	General Industrial Safety Orders
HCP	Hazardous Communication Program
HWMP	Hazardous Waste Management Plan
I&C Manual	Institution and Camps Manual
IIPP	Illness and Injury Prevention Program
MSDS	Material Safety Data Sheet
OAC	Office of Audits and Compliance
PM	Preventive Maintenance
PPE	Personal Protection Equipment
PYCF	Preston Youth Correctional Facility
SPCC	Spill Prevention Control and Counter
YAM	Youth Administrative Manual

COMPLIANCE PEER REVIEW

PRESTON YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

November 2008

STUDENT ENROLLMENT

Division of Juvenile Justice Education Manual, Sections 4065-4067, and Subsection of the California Education Authority, Section III (b)

Office of Audits and Compliance Staff
Eric Fransham, Parole Agent III
Ray White, Assistant Principal

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ) Education Manual, Sections 4065-4067, and sub-sections of the California Education Authority (CEA), Section III (b), to determine whether James A. Wieden High School (JAWHS) at the Preston Youth Correctional Facility (PYCF) is in compliance with the policies stating that students are to be enrolled into an appropriate educational program within four days of arrival to their assigned facility.

The review was performed during the period of November 17, 2007, through November 21, 2008. During this period, it was determined that JAWHS had a total of 257 wards that did not have their high school diploma or their General Education Certificate. There were four categories of students sampled; General Education, English Language Learner, Special Education, and Special Education/English Language Learner. The CPRB reviewed 36 student records from the Ward Information Network; an approximate sample size of 14 percent. From the English Language Learner category, 9 records were reviewed. In the Special Education category, 9 records were reviewed. From the Special Education/English Language Learner category, 9 records were reviewed. From the General Education category, 9 records were reviewed.

The principal and the primary school scheduler were interviewed to gain an understanding of the student enrollment process.

The CPRB determined that JAWHS is not in compliance with the CEA, Section III (b), and the DJJ Education Manual, Sections 4065-4067. The findings are as follows:

- Special Education/English Language Learner students are not enrolled within four days.

- General Education students are not enrolled within four days.

BACKGROUND

The CPRB met with the Supervisor of Correctional Education Programs for the Division of Juvenile Justice Education Department (DJJED) on December 20, 2007. The purpose of the meeting and subsequent meetings with the DJJED was to discuss the peer review process, to identify high risk areas, and decide on the highest risk areas to be evaluated during the peer review. Based on risk factor, it was determined that student enrollment within four days of arrival to his/her assigned facility would be reviewed.

Student enrollment was selected for review because students that are not high school graduates are mandated to be enrolled in school per the DJJ Educational Manual, Sections 4065-4067, and the CEA, Section III (b). Additionally, student enrollment within four days of arrival has been a problem area for DJJ schools in the past.

The specific objectives of the review were to determine whether:

- JAWHS is enrolling students into classes within four days of arrival to his/her assigned facility.

- JAWHS has a written educational operating policy to address student enrollment within four days of arrival to his/her assigned facility.

FINDINGS AND RECOMMENDATIONS

Finding I: Special Education/English Language Learner students were not assigned to school within four days of arrival.

Two out of nine (22 percent) Special Education/English Language Learner students were not enrolled into an appropriate educational program within four school days of arrival to the facility.

The first student was not enrolled into school within four days of arrival due to his arrival on a Friday night with the proceeding Monday the 13th being a holiday. These days were not counted in the four day enrollment process, although, they may have played a role in the missed time frames. The 15th and 16th were regular school days. The living unit the ward was housed in went on lock down on the 17th.

The second student was not enrolled into school within four days of arrival due to the wards lodge being closed and the ward having to move lodges during the school enrollment process.

Criteria:

CEA Education Services Branch, Section III (b), states: *"*As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendations:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Develop a written procedure to ensure that students are assigned to an appropriate educational program within four days of arrival to their assigned facility.

Finding II: General Education student not assigned to school within four days of arrival.

One out of nine (11 percent) General Education students was not enrolled into an appropriate educational program within four school days of arrival to the facility.

This student was not enrolled in the school program within the appropriate time frames due to construction being done on his class room during his school placement. The student was not enrolled into school within four days of arrival because the student transferred directly into PYCF's general population. The student was already committed to DJJ and was transferred to PYCF from another facility. Thus, the student did not go through the clinic process as a new commitment to DJJ.

Criteria:

CEA Education Services Branch, Section III (b), states: *"*As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendations:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Develop a written procedure to ensure that students are assigned to an appropriate educational program within four days of arrival to their assigned facility.

Review of Student Enrollment

PRESTON YOUTH CORRECTIONAL FACILITY

GLOSSARY

CEA	California Education Authority
CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
DJJED	Division of Juvenile Justice Education Department
JAWHS	James A. Wieden High School
PYCF	Preston Youth Correctional Facility

Information Security Compliance Review
Preston Youth Correctional Facility
November 20, 2008

The Office of Audits and Compliance, Information Security Branch (ISB) conducted an Information Security Compliance Review of the Preston Youth Correctional Facility on November 19, 2008. The review covered 15 different areas. Preston Youth Correctional Facility is compliant in 12 areas, partially compliant in 1 area, and noncompliant in 2 areas. The overall score is 84 percent. The chart below details these results.

FINDINGS SUMMARY:

		Score	Compliant	Partial Compliance	Non Compliant
STAFF COMPUTING ENVIRONMENT					
1.	Use Agreement (Form 1857) is on file.	94%	C		
2.	Annual Self-Certification of Information Security Awareness and Confidentiality forms are on file.	NA			
3.	Information security training is current.	NA			
4.	Staff log on are using own password.	100%	C		
5.	Network access authorization is on file.	95%	C		
6.	Physical locations of CPUs agree to inventory records.	95%	C		
7.	Staff CPUs labeled “No Ward Access.”	95%	C		
8.	Staff monitors are not visible to wards.	95%	C		
9.	Anti virus updates are current.	90%	C		
10.	Security patches are current.	NA			
WARD COMPUTING ENVIRONMENT (Education, Library, Clerks)					
11.	Physical location of CPUs agrees to inventory records.	100%	C		
12.	CPU labeled as ward computer.	17%			NC
13.	Anti virus updates are current.	0%			NC
14.	Ward monitors are visible to supervisor.	100%	C		
15.	Portable media is controlled.	100%	C		
16.	Telecommunications access is restricted.	100%	C		
17.	Operating system access is restricted.	83%		P	
18.	Printer access is restricted.	100%	C		

Overall 84 percent

OBJECTIVES, SCOPE AND METHODOLOGY

The objectives of the Information Security Compliance Review are to:

- Assess compliance to selected information security requirements.
- Evaluate other conditions discovered during the course of fieldwork that may jeopardize the security of information assets of the facility or of the Department.
- Provide information security training for management and staff.

In conducting the fieldwork, the ISB performs the following:

- Interview members of senior management, information technology (IT) staff, institutional staff, and computer users.
- Ask staff to provide evidence that all authorized computer users have Acceptable Use Agreement forms and the appropriate training support documentation on file.
- Tests selected information security attributes of users and IT equipment using three different population samples. This includes both staff and inmate computing environments.
- Review various laws, policies, procedures, related to information security in a custody environment.
- Conduct physical inspections of selected computers.
- Observe the activities of the IT support staff.
- Analyze the information gathered through the above processes and formulate conclusions.

FINDINGS AND RECOMMENDATIONS

The ISB provided a copy of our review guide to your IT staff. It contains audit criteria and a detailed methodology. That information, therefore, is not duplicated under each finding.

Each finding is referenced with appropriate list of the Institutions and Camps Manual (I&C Manual) or the State Administrative Manual (SAM) Section.

ISB's findings and recommendations are listed below. ISB staff discussed them with management in an exit conference following our fieldwork. Please contact us if you would like to discuss any of these issues further.

1. Ward computers were not labeled "For Ward authorized access." (17 percent compliance)

Recommendation: Each computer in a facility shall be labeled to indicate whether or not ward access is authorized. (I&C Manual, Sections 1910 and 5040; and SAM, Section 4840.)

Best Practice: Affix appropriate labels to <u>both</u> the monitor and the CPU.

2. Ward accessed computers do not have up-to-date antivirus software. (0 percent compliance.)

Recommendation: Update antivirus software on all wards computers. (SAM, Section 4841.2.)

3. All ward access to computer operating systems must be restricted. (83 percent compliance)

Recommendation: Restrict ward access to computer Operating System files. (I&C Manual, Sections 1725, 1910, and 5040; and DOM, Section 49020.18.3.)

COMPLIANCE PEER REVIEW

PRESTON YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

November 2008

USE OF FORCE

Division of Juvenile Justice, Temporary Departmental Order #06-73, Sections 2080-2107 - Use of Force

Office of Audits and Compliance Staff
Gil DeLyon, Captain

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ), Temporary Departmental Order (TDO) 06-73, Sections 2080 through 2107, to determine whether Preston Youth Correctional Facility (PYCF) is in compliance with the policy that identifies the peace officer responsibilities for applying force, reporting force, and reporting excessive and/or unnecessary force.

The review period for staff use of force (UOF) inquiries was January through November 2008. During this period, the CPRB reviewed the inquiry database and determined that PYCF had four staff inquiries relating to UOF. The CPRB selected all four inquiries to be included in the review. The review period for the Institutional Force Review Committee (IFRC) reports was January through February 2008. The CPRB identified a sample of 116 IFRC reports and as a result, the CPRB provided a critical analysis of ten percent of the reports to be included in the review. The findings are as follows:

The CPRB determined that PYCF is not in compliance with TDO 06-73, Section 2107.

- Staff inquiries are not completed within time frames.

- PYCF is not requesting a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

BACKGROUND

The CPRB met with the DJJ on January 8, 2008, to discuss areas of high risk. UOF was identified as a high risk area, due to both past litigation and court mandates. Therefore, based on risk factor, the CPRB determined that UOF would be a topic of review. The review will help to ensure that all time frames are met and the UOF reports are accurately documented.

The specific objectives of the review were to determine whether:

- UOF is reviewed at a supervisory and managerial level, and the IFRC is meeting on a monthly basis. (TDO 06-73, Section 2085.)

- Time frames have been met regarding all applicable reports, clarifications, and forms pertaining to the UOF report package. (TDO 06-73, Section 2102.)

    a. Captain/Major – Normally within 2 business days of receipt.

    b. Superintendent - Normally within 2 business days of receipt.

    c. IFRC – To review within 30 days.

    d. Departmental Force Review Committee.

    e. Bureau of Independent Review.

- The UOF reports are maintained in a database and the length of time the reports are retained. (TDO 06-73, Section 2106.)

- All inquiries regarding allegations of excessive or unnecessary force are assessed (no action needed, conduct an inquiry, or recommend a formal Internal Affairs investigation), and the reports are completed within the required time frames. Additionally, when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day extension through the chain of command to the Director of the Division of Juvenile Facilities. (TDO 06-73, Section 2107.)

FINDINGS AND RECOMMENDATIONS

Finding 1: Staff inquiries not completed within time frames.

Fifty percent of the UOF staff inquiries were not completed within 30-days. PYCF had 17 staff inquiries from January through November 2008. Of those, four were related to force. Two were completed within the 30-day time frame and two went beyond the 30-day inquiry time frame.

The CPRB determined through interviews, that the grievance coordinator initiates the staff inquiry process and assigns the 30-day staff inquiry to the appropriate manager. The superintendent's office receives the inquiry upon its completion. However, staff assigned to track the time frames in the superintendent's office, in some cases, are not made aware that the inquiry was completed and turned in.

This informal process directly relates to the 30-day inquiry time frames being exceeded by the facility. PYCF could address this area by directing the appropriate managers to deliver the completed inquiries to designated staff in the superintendent's office. This would formalize the process used to track staff inquiries.

Criteria:

TDO 06-73, Section 2107, states in part: "All inquiries shall be completed within 30 working days of the superintendent's review of the complaint/report of misconduct."

Recommendations:

Formalize the process used to track and record the facilities 30-day staff inquiries, by designating staff in the superintendent's office to receive and record the completed inquiries.

Create a spread sheet on a shared program, so that the grievance coordinator and the staff designated to record completed staff inquiries, have a quick reference sheet to record and track the 30-day staff inquiry process.

Finding 2: PYCF is not requesting a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

To determine PYCF's UOF process, the CPRB conducted several interviews with management and staff during the period of November 17 through November 21, 2008. As a result, it was determined that PYCF does not request a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

A memorandum dated October 27, 2008 has been forwarded to all DJJ superintendents requiring DJJ facilities to forward their 30-day staff inquiry time extension requests to the Division of Juvenile Facilities, Directors Office.

Criteria:

TDO 06-73, Section 2107, states: “If and when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day Inquiry Time Extension through the chain of command to the Director of the Division of Juvenile Facilities.”

Recommendations:

Formalize a process/system to track staff inquiries that exceed the 30-day staff inquiry time frame.

Request 30-day staff inquiry time extensions through the Director of the Division of Juvenile Facilities.

Review of Security Operations

PRESTON YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
IFRC	Institutional Force Review Committee
PYCF	Preston Youth Correctional Facility
TDO	Temporary Departmental Order
UOF	Use of Force

COMPLIANCE PEER REVIEW

PRESTON YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

November 2008

HEALTH CARE SERVICES REQUEST FORMS

Institutions and Camps Manual, Sections 6169 and 6255; and Revision IT-46, Section 6249.9.

Office of Audits and Compliance Staff
Karen Jennings, Treatment Team Supervisor
Teo Pique, Senior Psychologist, Supervisor

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Institution and Camps Branch Manual (I&C Manual), Sections 6169 and 6255; and Revision IT-46, Section 6249.9 to determine whether Preston Youth Correctional Facility (PYCF) is in compliance with the policies that identify the responsibilities of health care staff for treating, evaluating, and tracking wards that request mental health services by submitting a Health Care Services Request form, Division of Juvenile Justice (DJJ) 8.018.

The review period was July 1, 2008 through September 30, 2008. During this period, the CPRB reviewed the Health Care Services Request Tracking logs and found a total of 95 Health Care Services Requests submitted by wards in need of mental health services. The CPRB selected a 10 percent sample of wards requesting mental health services. Therefore, 10 wards and their Unified Health Records (UHR) were selected for review. Of the 10 wards selected, 4 submitted multiple requests. As a result 10 UHRs, and 16 Health Care Services Request forms were reviewed.

The CPRB determined that PYCF is not in compliance with the I&C Manual, Section 6255. The findings are as follows:

- Lack of documentation

- Psychologist's documentation not in the UHR.

BACKGROUND

In December 2005, an audit report was prepared by the Office of the Inspector General (OIG) documenting a ward's request for mental health services through the Health Care Services Request form. On four different occasions while assigned to PYCF, a ward requested mental health services. The ward's requests began in October 2004 and concluded in December 2004. Despite numerous requests, the ward never received treatment. One of the requests contained documentation by staff that the ward did not want to be seen. Follow-up was not indicated by a psychologist or psychiatrist.

In March 2005, the ward was transferred to N. A. Chaderjian Youth Correctional Facility (NACYCF). There was no indication in the UHR that the ward requested mental health services on four separate occasions. The ward was classified as a low suicide risk. The ward was assigned to an intake hall and eventually transferred to a general population hall. The ward did not receive proper intervention from his earlier requests, while assigned to PYCF.

While the ward was assigned to NACYCF, there was no documentation that the ward continued to request mental health intervention. In July 2005, the ward's hall went on lock down due to a serious staff assault. In August 2005, the ward successfully committed suicide.

As a result, the CPRB determined that the procedures for requesting mental health intervention by way of the Health Care Services Request form should be reviewed. The review will help to ensure that all wards who request mental health services by submitting a Health Care Services Request form will receive treatment and the intervention will be documented.

The specific objectives of the review were to determine whether:

- The Health Care Services Request forms are being processed according to the I&C Manual, Revision IT-46, Sections 6169 and 6255;
- Health Care staff is collecting the Health Care Services Request forms daily;
- Health Care Services Request forms are filed in the ward's UHR;
- Each form is signed and dated when they are collected, and entered on the Health Care Services Request Tracking log, DJJ 8.017; and
- The Registered Nurse (RN) reviews all requests including signing, dating, and placing the time in the designated areas.

The RN is prioritizing the requests by the following methods:

- Urgent requests shall be seen the day of the request;
- Routine requests shall be seen within one business day of the request; and
- Requests for mental health care may be referred to mental health services, if available within the time limits of urgent or routine priority.

Weekends and Holidays

- The health care staff is delivering all forms to the Outpatient Housing Unit (OHU) RN or designee on weekends and holidays after entering the form on the Health Care Services Request Tracking Log.

The OHU RN or designee shall:

- Review the form for mental health needs and establish priorities for each request on an urgent or routine basis;
- Sign, date, and time stamp the forms in the designated areas;
- Determine whether urgent conditions relating to mental health should be reported to the appropriate on site psychiatrist;
- The night before the next scheduled clinic, all routine requests shall be returned to the appropriate medical clinic for scheduling and to the appropriate mental health staff member for collection;
- Psychologists/psychiatrists are providing treatment to the wards making the requests. (Revision IT-46, Section 6249.9.);
- Psychologists/psychiatrists are placing documentation in the UHR that appropriate care has been delivered. (I&C Manual, Section 6255.); and
- Psychologists/psychiatrists are completing a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care using the Subjective Objective Assessment Plan (SOAP) format. (I&C Manual, Sections 6169 and 6255.)

The CPRB determined whether the objectives were met by reviewing:

- The I&C Manual, Sections 6169 and 6255, Revision IT-46; Temporary Departmental Orders; and the facilities operational manuals;
- The audit report prepared by the OIG; Special Review into the Death of a Ward on August 31, 2005 at NACYCF, December 2005;

- Health Care Services Request forms relating to mental health;
- Health Care Services Request Tracking logs during the period of December 1, 2007 through May 31, 2008;
- UHRs;
- Information obtained from interviews with health care staff members; and
- The Ward Information Network (WIN) system data.

FINDINGS AND RECOMMENDATIONS

Finding I: Lack of documentation

Of the 16 Health Care Services Request forms submitted for mental health services, 1 (6 percent) of the requests had no documentation in the UHR or the WIN, that the ward had been evaluated by the psychiatrist/psychologist.

The CPRB reviewed the Mental Health section of the UHR and the WIN system to verify that the ward received treatment by the psychiatrist/psychologist. As a result, the CPRB could not locate an evaluation from the psychiatrist/psychologist.

Upon further investigation, the CPRB verified the psychiatrist evaluated the ward by reviewing the Clinic's log. The CPRB determined the psychiatrist failed to document the assessment in the Chronological Record of Care.

Criteria:

Memorandum dated July 18, 2007, from the Supervising RN II.

I&C Manual, Section 6255, states: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;
- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;
- Describe the problem and/or present event, observations, clinical assessment, planned care, and anticipated results;
- Use the SOAP format for recording, as outlined in the I&C Manual, Section 6169, UHR;
- Record summaries of individual interactions, group mental health interactions, and program progress; and
- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendation(s):

Ensure all Health Care Services Request forms are responded to by all responsible parties.

Develop a monitoring system with the supervisors (or designee) ensuring that all Health Care Services Request forms are responded to and followed through.

Ensure all staff contacts with the ward in response to the Health Care Services Request forms are documented in the Chronological Record of Care.

Provide staff training regarding processing the Health Care Services Request forms.

Finding II: Psychologist/psychiatrist's documentation not in the UHR

Of the 16 records of documentation reviewed, 2 (13 percent) were in the WIN system, but not printed and placed in the UHR.

The CPRB did not find a printed copy of the Chronological Record of Medical Care that documented the ward's mental health treatment regarding his Health Care Services Request form in the UHR. The CPRB found the missing UHR documentation in the WIN system.

The CPRB determined the lack of documentation in the UHR is due to the printed copy of the Chronological Record of Medical Care being lost, misplaced, waiting for a supervisor's signature, or not initially printed and placed in the UHR.

Criteria:

I&C Manual, Section 6255: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;
- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;
- Describe the problem and/or the present event, observations, clinical assessment, planned care, and anticipated results;
- Use the SOAP format for recording, as outlined in the I&C Manual, Section 6169, UHR;
- Record summaries of individual interactions, group mental health interactions, and program progress; and
- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendation(s):

Ensure all staff evaluating the ward, in response to the Health Care Services Request form, is documenting the assessment in the WIN and printing out the documentation for placement in the UHR.

Develop a monitoring system to verify WIN documentation of the assessment, is placed in the UHR.

Provide staff documentation training to ensure placement of WIN information in the UHR.

Review of Health Care Services

PRESTON YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
I&C Manual	Institution and Camps Branch Manual
NACYCF	N. A. Chaderjian Youth Correctional Facility
OHU	Outpatient Housing Unit
OIG	The Office of the Inspector General
PYCF	Preston Youth Correctional Facility
RN	Registered Nurse
SOAP	Subjective Objective Assessment Plan
UHR	Unified Health Record
WIN	Ward Information Network

COMPLIANCE PEER REVIEW

PRESTON YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

November 2008

SAFETY AND SECURITY STANDARDS, SECTION 1800

Division of Juvenile Justice, Institutions and Camps Branch Manual, Section 1800 - Safety and Security Standards Review

Office of Audits and Compliance Staff
Gil DeLyon, Captain

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ), Institutions and Camps Branch Manual (I&C Manual), Safety and Security Standards, Sections 1800 through 1817, to determine whether Preston Youth Correctional Facility (PYCF) is in compliance with the policies that identify the facility's responsibilities in addressing safety and security procedures.

The review period for the Safety and Security Standards, Section 1800 review was November 2008. During this period, the CPRB reviewed control of ward movement, multi-hazard emergency plans, the intercom system, key control, perimeter security, radio communications, operations manual, and the security alarm and sound monitoring system. The findings are as follows:

The CPRB determined that PYCF is not in compliance with Safety and Security Standards, Section 1807.

- The Multi-Hazard plan did not contain contact information for the Office of Emergency Services (OES).

- The Multi-Hazard plan did not contain a signed local mutual aid agreement with local law enforcement.

BACKGROUND

The CPRB met with the DJJ on January 8, 2008, to discuss areas of high risk. Safety and Security was identified as a high risk area, due to both past litigation and court mandates. Therefore, based on risk factor, the CPRB determined that Safety and Security would be a topic of review.

In addition, the Office of the Inspector General (OIG) conducted an audit in 2007 and concluded that DJJ Headquarters was not performing the required security audits as directed by the I&C Manual, Section 1800. In 2008, DJJ Headquarters began to implement the OIG's recommendations by conducting a self audit of DJJ facilities.

The purpose of this review is one of overall analysis and evaluation of the facilities compliance with the terms and conditions of operational security.

The specific objectives of the review were to determine whether:

- The facilities are in compliance with the Safety and Security Standards, Section 1800 policies that identify to the facility, their responsibilities in addressing safety and security procedures.

FINDINGS AND RECOMMENDATIONS

Finding 1: The Multi-Hazard plan did not contain contact information for the Office of Emergency Services.

PYCF has contact information for DJJ and local law enforcement in the Multi-Hazard plan binder, but the contact information for OES was missing. This was an over-site by PYCF; therefore, the CPRB sent the web link via electronic mail to OES, so that PYCF could include the required contact information in its Multi-Hazard Plan.

Criteria:

Safety and Security Standards, Section 1807, states: "The plan included the immediate notification of the emergency situations to the OES Warning Center and to the Youth and Adult Correctional Agency."

Recommendation:

Place the OES contact information into Section 1807 of the Multi-Hazard plan.

Finding 2: The Multi-Hazard plan did not contain a signed local mutual aid agreement with local law enforcement.

PYCF meets both monthly and yearly with local law enforcement and officials with Mule Creek State Prison (MCSP) to discuss safety and security issues and prepare for emergency situations. However, at this time local law enforcement and MCSP have been reluctant to formalize a written mutual aid agreement with PYCF; therefore, a verbal agreement is currently in place.

Criteria:

Safety and Security Standards, Sections 1807, states: "Superintendent/designee meets yearly with local law enforcement officials who have jurisdiction for the area where the institution is located, to plan for an emergency."

Recommendation:

The CPRB is not able to provide a recommendation, as local law enforcement is outside the scope of this office.

Review of Security Operations

PRESTON YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
I&C Manual	Institution and Camps Branch Manual
MCSP	Mule Creek State Prison
OES	Office of Emergency Services
OIG	Office of the Inspector General
PYCF	Preston Youth Correctional Facility